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# Therapist accounts of how cases become long-term in a training clinic.

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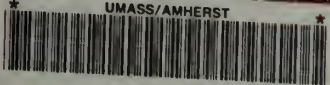
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THERAPIST ACCOUNTS OF HOW CASES BECOME LONG-TERM IN A  
TRAINING CLINIC

A Thesis Presented

by

JENNIFER DAVIDTZ

Submitted to the Graduate School of the University of Massachusetts in partial  
fulfillment of the requirements for the degree of

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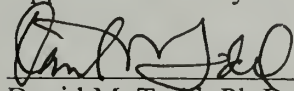
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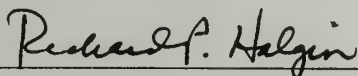
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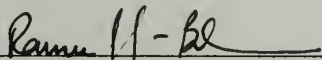
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## ABSTRACT

### THERAPIST ACCOUNTS OF HOW CASES BECOME LONG-TERM IN A TRAINING CLINIC

MAY 2004

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The present study described recent long-term cases in the PSC, and looked in-depth at the process by which five of these cases became long-term. The study used a mostly qualitative, case-oriented methodology to gain insight into therapists' considerations regarding length of treatment, formulation of decisions regarding length of treatment, and the processes by which cases may develop into long-term cases. A brief descriptive analysis of adult psychotherapy cases in the PSC was conducted, suggesting that about one-fifth of cases in this setting become long term (52 sessions or greater) and that long-term cases constitute about one-third of cases that are open at any given time. From the available long term cases, 12 were considered for interviews. Those 12 cases were systematically reviewed using case records and these data provided the basis for the selection of five cases to be included in the interview stage. The current, or most recent, therapists involved on each of the five cases were interviewed using a set of open-ended questions. A qualitative, theme-based analysis of the data indicated that, for these cases, long-term therapy was rarely stipulated in the initial treatment plan and, when it was, it was seldom accompanied by an explicit rationale. Furthermore, the data suggest that it may be possible to identify client problems or characteristics for which long-term

psychotherapy may be indicated. Finally, for the cases considered in this study, therapists' recommendations and decisions regarding length of treatment were generally consistent with clients' treatment requests.

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## CHAPTER I

### LITERATURE REVIEW

Treatment frequency and duration are important considerations in treatment planning. In 1963, Malan wrote about the lengthening of psychodynamic therapy from its initial and intended brief duration. He attributed this trend to the increasing passivity of therapists, as reflected in their willingness to follow the lead of the patient in therapy towards increasing exploration of deeper and earlier experiences, thereby conveying a sense of timelessness. In 1981, Wilson asserted that behavior therapy had retained the brevity intended in its initial design, presumably as a result of the specificity of behavioral goals in this treatment orientation (Beutler & Clarkin, 1990). In their recent chapter on long-term psychotherapy, Crits-Cristoph and Barber (2000) report that the average length of psychotherapy is now decreasing as a result of health maintenance organizations (HMOs) and managed care companies, with only 28 percent of patients remaining in treatment for one year or more. Such contradictory and changing views of what constitutes “long-term” when referring to psychotherapy call for a current working definition. Crits-Cristoph and Barber (2000) propose a definition of long-term therapy as one year or more in duration based on the fact that, since short-term therapy has been defined as up to 25 sessions, “long-term therapy must be of sufficient duration to be clearly beyond six months” (Crits-Christoph & Barber, 2000). They acknowledge that therapists may consider one year of therapy as “a relatively common, somewhat brief treatment” and may view “long-term as a more appropriate label for those treatments that last several years.” Crits-Cristoph and Barber (2000) ascribe this view to what Cohen and Cohen (1984) refer to as the clinicians’ illusion: “The clinicians’ illusion has its

source in the fact that, while the majority of patients attend relatively few sessions, the majority of therapists' time is spent with longer-term patients." (Crits-Christoph, 2000). Some therapists, because of a potentially self-serving bias towards long-term psychotherapy, and some patients, because of lack of knowledge, may be vulnerable to engaging in long-term therapy without ever reviewing the issue of whether it is the most appropriate form of treatment. Conversely, it appears that the current managed care environment increasingly places an emphasis almost exclusively on brief therapies for financial reasons.

Logically and ethically, treatment duration should be determined by clinical factors (what is the most effective treatment for the client's problem) rather than such extrinsic factors as therapist bias, lack of client awareness and cost-saving. While, in general, it is not disputed that a greater total amount and longer duration of treatment predict greater benefit to the client (Beutler & Clarkin, 1990), there are both psychological and financial reasons for avoiding longer term treatments when their necessity has not been adequately evaluated. It is therefore important for us, as clinicians and researchers, to determine the role of long-term psychotherapy in the current environment. If there are particular types of problems for which long-term therapy may be indicated, then we are charged with the responsibility of identifying such problems with the goal of providing clients with the best possible treatment while also ensuring the most effective distribution of available resources.

Budman and Gurman (1988) proposed that these decisions may sometimes be based on therapist values, rather than on rational evaluation of need. They proposed that all therapists have both spoken and unspoken values regarding the ideal manner in which



therapy is practiced, and developed a comparative list of eight value ideals of the long-term and the short-term therapist (see Table 1).

Budman and Gurman (1988) acknowledge that numerous therapists practice both long-term and short-term therapy and that the divergences represented in these eight values may not be dichotomous. Bolter, Levenson and Alvarez (1990) empirically examined these proposed differences in value ideals and found that the only two value areas in which long-term and short-term therapists differed significantly were the “timelessness” of therapy and the nature of psychological change. Long-term therapists value a “timeless” quality in therapy whereas short-term therapists value an awareness of limited time in therapy. In terms of psychological change, long-term therapists were more likely to hold the view that personalities are essentially static and require work in therapy to overcome resistance to change. However, short-term therapists took a more adult developmental perspective in which change is viewed as inevitable.

Bolter, Levenson and Alvarez (1990) also found that several of the eight value areas proposed by Budman and Gurman (1988) were significantly related to theoretical orientation but not to preference for long- or short-term work. They conclude from this that, regardless of time orientation, whether therapists seek major personality change and focus on underlying pathology, or seek specific changes and focus on strengths, seems to be dictated in large part by whether the therapist is an analyst, a humanist or a behaviorist.

Although there is an extensive literature on factors predicting the outcome of psychotherapy, few studies have directly addressed the question of what types of patients specifically benefit from long-term psychotherapy (Crits-Christoph & Barber, 2000). A

widely held view in the brief therapy literature regarding long-term treatment is that it should only be considered if brief therapy has been unsuccessful (Wolberg, 1965; Budman & Gurman, 1983).

Beutler and Clarkin (1990) challenge this conclusion and argue that there are many clinical situations in which time-limited treatment would be inappropriate even as a first trial. According to their model of Systematic Treatment Selection, there are a number of important patient characteristics that tend to lengthen treatment, “including poor or variable patient motivation, problem severity and complexity, failure to accomplish therapy assignments, and lack of social and family support.” They assert that one cannot consider the duration of a treatment without at the same time considering the breadth or complexity of a patient’s problem. In this model, problem severity “represents the degree to which the patient’s problems interfere with and disrupt his /her daily social, occupational and interpersonal functioning. Related concepts include coping ability, ego strength, some aspects of cognitive ability, and problem chronicity. It is also related to the availability of environmental support (social and familial), since these are forces that increase the ability to cope.” (Beutler & Gaw, 1995). Problem complexity is related to problem severity: “A complex problem is defined as one that is pervasive and enduring; it is chronic and transsituational rather than situation-specific and acute” (Beutler & Clarkin, 1990).

Therapists, as a group, tend to consider short-term treatment as most appropriate for patients with situational reactions, narrow band and unidimensional problems (Budman & Gurman, 1983; Burlingame & Behrman, 1987, as cited in Beutler & Clarkin, 1990). There may be less consensus on when longer term treatment is needed. However,

some have argued that the more complex the problem, the more the treatment objectives should be focused on the driving, underlying conflicts, and the longer the therapy probably will be; that is, diagnoses that involve serious, chronic or recurring conditions, as well as personality disorders, suggest treatments of longer duration (Beutler & Clarkin, 1990; Crits-Christoph & Barber, 2000; Kopta, Howard, Lowry & Beutler, 1994). The ability of patients to focus on one or several central issues in therapy will tend to shorten the duration of treatment, whereas poor motivation for treatment or change will lengthen treatment (Beutler & Clarkin, 1990). Furthermore, matching of the therapist and patient on a number of demographic and personality variables potentially shortens treatment since compatibility would increase the ease and speed with which a focus for treatment could be achieved (Beutler & Clarkin, 1990).

A study examining factors influencing clinicians' recommendations of treatment length in the PSC found that clinicians' ratings of Global Assessment of Functioning at intake and "Complexity" were significant in predicting recommendations for treatment length (McRae, 1998). Complexity is the label assigned to one of two factors produced by a principle-component factor analysis of 15 items on the Length Factors Questionnaire, a rating form designed by David Todd and Pat McKenna to measure factors that may affect the length of treatment a therapist recommends. It is defined as "a client who is difficult; is not appropriate for a training clinic, or for brief therapy; has difficulty separating; prefers long-term therapy; needs crisis intervention and has a complex problem" (McRae, 1998).

These results, particularly the client characteristics described by "complexity," are consistent with Beutler and Clarkin's (1990) model of systematic treatment selection and

offer a glimpse into one way clinicians think about length of treatment at intake; however, they do not tell us anything about the process by which therapy cases develop as long-term. This is a complex question, and exploratory research is needed to help identify relevant factors, and the ways they might interact over time.

Participating in the process of case assignment in a training clinic has raised some questions regarding decisions around treatment duration in the Psychological Services Center (PSC). Clinician and supervisor statements like, “this person needs at least a year” or “I think this case is going to be long-term” suggest an intuitive element to these decisions, but such intuition must be informed by a more systematic rationale. The literature reviewed above suggests a number of factors that influence treatment duration, including therapist values, client characteristics and the nature of the therapeutic relationship. Identifying factors that may predict length of treatment and the process by which these factors operate in various aspects of therapy (case assignment, initial conceptualization and treatment planning, and the course of treatment), have enormous implications for treatment planning. Clinical trainees’ perspectives on decisions around treatment planning are unique in that they fulfill a number of important roles on multiple levels while still in training; these roles range from screening potential clients, to participating in decisions regarding case assignment, to working closely with their own clients as therapists.

The present study proposed to describe the recent long-term cases in the PSC, and then to look in-depth at how a small number of these cases came to be long-term, as documented in the case record and as viewed by the therapist. The study used a mostly qualitative, case-oriented methodology to gain insight into therapists’ considerations



regarding length of treatment, formulation of decisions regarding length of treatment, and the processes by which cases may develop into long-term cases. Research questions included the following:

1. Was long-term therapy stipulated in the initial treatment plan or did the case develop into long-term over time?
2. If long-term therapy was recommended at the outset, what rationale was provided for this recommendation?
3. Can we identify client problems or characteristics for which long-term psychotherapy may be indicated?
4. Was the decision about length of treatment made passively (e.g., by not raising it explicitly and just continuing until the topic of termination was raised) or actively (by declaring it on some level as a long-term case)?
5. How are these decisions related to the clients' initial and continuing notions of therapy and the length of therapy that they might want?

## CHAPTER II

### METHOD

This study consisted of three phases: 1) identification of recent long-term cases, 2) review of the records of the pool of possible interview cases, and 3) interviews with selected therapists who were involved with some of those cases.

#### The Setting

The Psychological Services Center (PSC) is a training clinic that provides services to students at the University of Massachusetts as well as to members of surrounding communities. Therapists in the PSC are doctoral students in the clinical psychology program who are in their second year or greater, as well as a small number of post-doctoral clinical respecialization students. Therapists are supervised by licensed clinical psychologists who are either permanent faculty members or adjunct faculty in private practice in the community.

The PSC is open to the surrounding communities as well as the university, and about two-thirds of clients are undergraduate or graduate students. The PSC accepts referrals from the Mental Health Division of University Health Services for open-ended or longer term psychotherapy. The clinic operates on a sliding fee scale, and does not exclude clients on the basis of inability to pay for services. It is thus one of the few places in the community where low-cost long-term treatment is available. Initial screenings are conducted by phone and, since all therapists in the PSC are beginning clinicians and the clinic does not provide 24-hour crisis coverage, high-risk cases are screened out and referred to more appropriate treatment settings in the community. Case assignments are made at a weekly intake meeting, where a concerted effort is made to

match clients to therapists in a way that best meets the treatment needs of the client, as well as the training needs of the therapist.

### Selection of Cases and Participants

For the purposes of this study, “long-term” was broadly defined as a minimum of 52 sessions. Two sets of cases were identified from which recent or current long-term cases could be drawn: (1) all the individual adult therapy cases (seen for at least one session) in the PSC that remained open on 10/25/02 (“Open Pool”); and (2) all the individual adult therapy cases in the PSC that had closed between 9/1/99 and 10/25/02 (“Closed Pool”). This resulted in a total of 168 cases, with 31 "Open" cases and 137 “Closed” cases.

Of these cases, some had been seen continuously by one therapist, while others had been transferred one or more times. Also, some clients had been seen for more than one "case" of individual therapy in the PSC, since a new case ID was assigned whenever a client resumed treatment after a break of 6 or more months. For the purposes of this study, we defined the number of sessions of individual therapy for each client to include sessions with all therapists on all of the individual therapy cases in which the client had been involved in the PSC. There were 10 cases with at least 52 sessions in the open pool (32%) and 32 cases with at least 52 sessions in the closed pool (23%). Since descriptive information about these samples provides an interesting view of the length of cases in this training clinic, additional detail will be presented below in the results section.

Using these selection criteria, it was possible that the current or most recent therapist on some of the cases which had involved transfers might have seen the client for only a brief time. Only therapists who had been involved with particular long-term cases

for a sufficient amount of time to have participated in decision-making regarding the development or maintenance of these cases as long-term were considered for inclusion in interview phase of this study. Also, for the closed cases some of the therapists were close enough geographically to be interviewed, while others were not, which was also taken into account in the selections.

Of the 10 long-term cases in the open pool, there were 6 cases for which the current therapist had met with the client for at least 52 sessions. Of the 32 long-term cases in the closed pool, 23 of these cases were excluded because the most recent clinician was no longer available for interviewing. Of the remaining cases, there were 5 for which the most recent therapist who had seen the client for at least 52 sessions was still available for an interview. Those 11 cases (open and closed, long term cases, with an available therapist) were distributed across a total of 8 therapists, three of whom had seen two clients for at least 52 sessions, and 5 of whom had seen one client for at least 52 sessions.

One additional case was considered for inclusion, despite the fact that it did not meet the criterion that the current or most recent therapist had seen the client for at least 52 sessions. This case was included in the pilot interview (see below) and was subsequently assigned to a new therapist and remained open at the time of case selection. Even though the most recent therapist had only had the case for a dozen sessions at the time of case selection, the client had been seen for a large number of sessions (374) in the PSC by a total of 5 therapists over a period of 10 years. In addition, the researcher had already interviewed the previous (4<sup>th</sup>) therapist, who saw the client for 30 sessions, as part of the pilot interview. That interview had suggested that the case must highlight



some important issues in long term treatment, so the possibility of including the case in the interview study was considered.

The preliminary selection process outlined above resulted in 12 cases being considered for the interview stage of the study (“interview pool”). One case was excluded early in the final selection process because the client was transferred to the researcher when the previous therapist left for internship. The remaining 11 cases were reviewed in terms of case information and demographic variables. Cases were then selected from this pool to comprise a final selection of 5 cases (“interview sample”) that were diverse with respect to characteristics or dimensions of interest including presenting problem, client level of functioning and client reasons for seeking therapy. While the cases were selected primarily according to client characteristics, the final selection was also determined by the availability and willingness of therapists to participate. One therapist had more than one case included in the interview pool and, since the cases were diverse with respect to the dimensions of interest indicated above, both cases were included in the final selection.

### Interview Sample

#### Case 1

The client, Kimberly, was referred to the PSC for anxiety related to trauma experienced in a past abusive relationship. She had been in therapy in a different setting for one year prior to seeking services here. She saw a therapist in the PSC for 54 sessions; when this therapist left for internship, she was transferred to the therapist, Linda, whom, at the time of the interview, she had seen for a total of 93 sessions over a period of 3 years. The therapy was terminated because Linda was no longer going to be

seeing clients in the PSC. Linda was a doctoral candidate in clinical psychology at the University of Massachusetts at Amherst. She had been seeing clients in the PSC for 3 years. She described her theoretical orientation as integrative; however, she noted that her conceptualization of cases was predominantly psychodynamic.

#### Case 2.

The client, Steven, had been in individual psychotherapy at the PSC for 10 years. He had seen a total of 6 therapists during that period for a total of 360 sessions. At the time of the interview, he had been seeing the current therapist, Janet, for 29 sessions over a period of 11 months. His original treatment request was for “general help” with regard to self worth and relationships; furthermore, he had indicated that his life partner “required” him to be in therapy. His work with Janet focused on helping Steven to improve his self-esteem and develop skills to cope with social anxiety, improve his ability to make decisions and improve his functioning in interpersonal relationships. Janet was a student in the doctoral program in clinical psychology at the University of Massachusetts at Amherst. She had been seeing clients in the PSC for 11 months when she was interviewed. She described her theoretical orientation as cognitive-behavioral.

#### Case 3.

Sylvia sought services at the PSC for childhood, family and relationship trauma; furthermore, she indicated that she “always want[ed] to have an outlet and someone to keep [her] problems in perspective.” She saw a previous therapist for 27 sessions over a one year period; the therapy terminated when the therapist left to go on internship. Two months later she returned to the PSC and requested to see Carla. She saw Carla for a

total of 70 sessions over a period of two years. One month after this interview, Carla and Sylvia terminated therapy because Sylvia left the area.

Carla was an advanced doctoral student in the clinical psychology training program at the University of Massachusetts at Amherst. She had been seeing clients in the PSC for 3 years at the time she participated in an interview for the present study. She described her theoretical orientation as integrative.

#### Case 4.

Barbara sought services at the PSC for anxiety, depression, poor interpersonal skills and Attention Deficit Disorder. Although she had scheduled a total of 59 appointments, thus meeting the criteria for inclusion in the present study, she only saw Carla for a total of 49 sessions over a period of two and a half years.

#### Case 5.

Lydia self-referred to the PSC for help dealing with her mother's mental illness, past sexual assault and abuse, an eating disorder, low self-esteem and depression. She saw Stephanie for a total of 78 sessions over a period of three years. This therapy was terminated 2 months prior to the interview because Stephanie was no longer going to be seeing clients in the PSC and Lydia was transferred to another clinician. At the time of the interview, Stephanie was a doctoral candidate in clinical psychology at the University of Massachusetts at Amherst. She had been seeing clients in the PSC for 3 years. She described her conceptualization of cases as predominantly psychodynamic and her approach to treatment as integrative; however, she emphasized an insight-oriented approach to psychotherapy.

## Procedure

A brief descriptive analysis of the two samples of adult individual psychotherapy cases in the PSC that were open on 10/25/02 or had closed between 9/1/99 and 10/25/02 was conducted. This description consisted of information that was readily available in the PSC database, such as the length of time clients had been involved in treatment at the PSC; the gender distribution of clients in the PSC; the number of cases in which individuals had been involved; the number of clinicians that had been assigned to cases and the number of sessions with each of these clinicians; and the proportion of scheduled sessions kept. The purpose of this analysis was to provide some context for long-term cases in the PSC, specifically the 12 cases that comprised the interview pool and the final sample of cases included in the interview phase. Some details of this analysis are included below in the results section.

The 12 cases included in the interview pool were similarly described, and then systematically reviewed using case records, including the Personal History Questionnaire (PHQ), the Personality Assessment Inventory (PAI), therapist intake reports, treatment plans, contact notes and transfer summaries. These data provided the basis for the selection of five cases to be included in the interview stage.

The final stage of the study consisted of interviews with 4 clinicians, covering 5 cases. Although case records were utilized in the process of data collection, documentation of discussion and decisions with respect to length of treatment was limited, thus the bulk of the data was obtained from the interviews with therapists. A set of open-ended questions was used to guide the interviews (see Appendix A), but this format was modified as necessary to gain the richest, most detailed description of each



individual therapist's conceptualization of the case being discussed. The length of interviews ranged from 45 to 75 minutes.

### Pilot Interview

An informal pilot interview was conducted prior to the formal study. One purpose of this interview was to confirm the extent to which the proposed study would be possible and useful. Another was to gather information about a few long-term cases in the PSC that would be useful in developing interview questions and, more broadly, a framework for this study. The interviewee was an advanced doctoral trainee who, at the time of the interview, was assigned to three cases in the PSC. She discussed the three clients to whom she was assigned at the time; she had seen these clients for approximately 65, 20 and 40 sessions, respectively.

Some dimensions of interest that arose from this interview include clients' reasons for seeking therapy, for example, personal growth; personality factors, such as dependency; history of trauma or abuse; degree of psychopathology, for example, substance abuse; risk factors such as past suicide attempts; and current (at time of interview) usefulness of therapy. Table 2 illustrates some ways in which these issues came up across the three different clients.

### Data Analysis

All interviews were tape recorded and verbatim transcripts of those recordings were prepared by the principal investigator. Interview transcripts were read and reread carefully and integrated with data obtained from case records in order to develop as complete a picture as possible of each case being studied. The objectives of this study were to (1) gain an in-depth understanding of each of these individual cases in terms of

the research questions outlined above; (2) identify some of the factors that should be included in a general model of determining treatment duration using a predominantly theme-based analysis of the data; (3) try to develop an understanding of some of the reasons why long-term therapy may be recommended; (4) illuminate some of the ways in which cases develop into long-term, including decisions made during this process; and (5) identify client problems or characteristics for which long-term therapy may be helpful.

### Confidentiality

The need to protect the confidentiality of participants, including clinicians, supervisors and clients, at times necessitated limiting the detail of case information presented. This sometimes involved the exclusion or modification of identifying information. Despite these limitations, care was taken to preserve the essence of the case being discussed and to ensure that what was conveyed was true to that spirit. The Chair of the thesis committee is the Clinic Coordinator and therefore has access to all documented case information; however, participants were asked to what extent they would be comfortable with the researcher sharing detailed interview data with the chair and other committee members. All participants granted permission to share detailed data, and the committee Chair was consulted throughout the process, especially in efforts to preserve the essence of participants and cases while maintaining confidentiality.

### Researcher

I am a third year clinical trainee and have been seeing clients in the PSC for approximately 18 months. Clinical work, the process of reviewing the literature on long-term psychotherapy for this study, and time spent with the data have increased my

awareness of my own bias towards a time-unlimited or open-ended approach to therapy, which often implies long-term. I think long-term therapy is often necessary for complex problems, such as enduring dysfunctional patterns in relationships or in cases where the client has a history of trauma or abuse. This belief is due, in part, to my tendency towards a dynamic and exploratory approach to psychotherapy, which emphasizes the influence of early relationships on current relationships and functioning. I also believe that long-term psychotherapy is justified for personal growth; however, this becomes problematic in terms of the allocation of limited resources and, in this regard, is perhaps less justifiable as a focus for treatment than clearly identifiable distress or dysfunction.

The approach of this study was exploratory and my intention was to learn whether, indeed, there are problems or characteristics for which long-term therapy may be indicated. Although I strove throughout the process to be receptive to new information in favor of attempting to confirm my existing beliefs, I must acknowledge that my interpretation was undoubtedly influenced by these beliefs.

## CHAPTER III

### RESULTS AND DISCUSSION

#### Description of Case Selection Samples

The characteristics of the sampling pools provide a general description of length of treatment, and the nature of long-term cases, in the PSC. The 31 cases that were open on 10/25/03 are described in Table 3. These cases had medians of 17 scheduled appointments and 15 sessions attended. For 10 (32%) of these cases, clients kept more than 52 of the scheduled sessions (“long-term”), with a range from 52 to 343 sessions. The number of sessions kept for the remaining 21 cases (68%) ranged from 1 to 30. The cases described in this sample should be reasonably representative of the PSC caseload on any given day, which suggests that about one-third of the continuing case load in the PSC involves long-term cases.

The 137 cases that closed between 9/1/99 and 10/25/02 are summarized in Table 4. These cases had medians of 20 scheduled appointments and 15 sessions attended. For 28 (20%) of these cases, clients kept more than 52 of the scheduled sessions (“long-term”), with a range from 52 to 227 sessions. For the remaining 109 cases (80%), the number of sessions attended ranged from zero to 50. The cases from this three year period should be reasonably representative of all cases in the PSC, suggesting that approximately one-fifth of cases that are seen in the PSC over time become long-term.

The 12 cases that were considered for inclusion in the interview stage of this study were drawn from the two samples described above and in Tables 3 and 4. Seven, including the case that did not meet general inclusion criteria, were contained in the open

pool and 5 were contained in the closed pool. The cases in the open pool had medians of 17 scheduled appointments and 15 sessions attended. The median age of clients on 10/25/02 was 26. Further descriptive data for these cases are presented in Table 3. The cases in the closed pool (Table 4) had medians of 20 scheduled appointments and 15 sessions attended and the median age of clients at termination was 22.

The 5 cases that comprised the interview sample (Table 6) were all included in the open pool and were among the longer cases in the PSC. For these cases, the median number of sessions scheduled was 102, with a range from 150 to 374; the median number of sessions attended ranged from 133 to 343, with a median of 83. The median age on 10/25/02 was 29.5. The case with a total of 343 sessions attended was, in fact, the longest case represented in any of the samples described above.

### Therapist Interviews

The results from the therapist interviews will be described in terms of the following issues: recommendation of long-term therapy in the initial treatment plan; the extent to which treatment was discussed with the client; therapists' understanding of the reasons these cases are long-term; relation of therapists' reasons for recommending long-term therapy to clients' treatment requests and notions of therapy; how therapists in training conceptualize long-term therapy; therapist views regarding the goals of psychotherapy; and client problems and characteristics for which therapists would recommend long-term therapy.



## Recommendation of long-term therapy in the initial treatment plan

Of the four therapists interviewed, only Carla explicitly recommended long-term therapy, and she did so only for Barbara. Her recommendation was based primarily on the client's request for therapy:

...like just one thing after the next in her history, and kind of was calling just saying like, so I need to be in therapy because of all this. So it wasn't like 'I have this specific problem that I want to work on' and so that kind of goes back to how I conceptualize long-term therapy...it's kind of like you see all these issues and you just have no idea where you'd begin and neither does the person, and so if neither of you know [sic] where to start, it just seems natural to be like, this is going to take some time. So for her, it just seemed like that's what made sense. I mean, what are we going to do with brief therapy if she's not requesting something specific?

Regarding Sylvia, for whom she did not explicitly recommend long-term therapy, she noted that, because Sylvia had already been in therapy at the PSC for a couple of years, "she was already targeted as a long-term therapy case...I picked up her case knowing that it would be a long-term therapy because of her history."

Linda did not explicitly recommend long-term therapy; however, she recommended insight-oriented treatment to explore experiences in Kimberly's history that contributed to current difficulties.

Janet, in addition to a number of specific short-term goals, recommended the general goal of "helping [Steven] develop skills, confidence and self-esteem to pursue goals, activities and relationships that were previously troublesome or unfulfilling." Although there is no explicit mention of treatment length, the breadth as well as the content of this goal suggests open-ended, and perhaps long-term, treatment.

Stephanie did not specify long-term therapy in the treatment plan, but did state that she "intend[ed] to use both problem-solving/restructuring and insight-oriented

approaches.” The absence of an explicit statement regarding length of treatment may be partly a result of her mentioning earlier in the report that Lydia “expressed interest in being in long-term treatment to deal with these long-standing issues.”

In summary, although Carla explicitly recommended long-term therapy in the treatment plan for one of her clients, the other therapists’ recommendations of long-term therapy were mostly implicit. Specifically, Linda and Stephanie recommended insight-oriented therapy and Janet recommended a number of broad goals that included enhancing self-esteem and altering relationship patterns. Since insight-oriented therapy is rarely suggested for specific, circumscribed problems, but frequently suggested for pervasive and long-standing core issues, it may be argued that it is synonymous with long-term therapy; however, it is not clear from the reports whether or not this was the rationale underlying Linda and Stephanie’s recommendations. In terms of Janet’s client, Steven, the length of his treatment at the PSC thus far may suggest that long-term therapy is necessary for the achievement of these goals.

Whether long-term therapy was explicitly recommended or not, none of the therapists interviewed place a limit on the length of therapy in the initial treatment plan. Furthermore, the length of treatment was rarely discussed either in supervision or with the client (refer to next section). This suggests that, in the PSC, the length of treatment is seldom explicitly considered in treatment planning unless a client has requested a specific number of sessions, or there is an externally imposed deadline, such as an impending move. This has positive implications for training in terms of the valuable opportunity to work with clients for an extended period of time; however, the importance of being trained in brief interventions cannot be underestimated, particularly in the context of the

movement towards managed health care. Moreover, this raises the issue of the distinction between time-limited and open-ended therapy and its relation to short-term and long-term therapy. This will be explored further in the next chapter.

#### Extent to which length of treatment was discussed with the client

Linda reported that she and Kimberly did discuss the length of the treatment; however, it was later in the treatment and not in the context of treatment planning: “...[the client] was imagining being ready for the end of therapy, you know, she could finally see that there might be an end in sight; we talked about that and also talked about my leaving...but we didn’t plan for how long it was going to take.”

Janet reported that she had never discussed treatment length with Steven, but that the topic was often addressed indirectly:

No, we really haven’t. I mean, he talks extensively about past therapists...refers to the fact that he’s been here a long time and he talks about how his therapists stay the same age, but he keeps getting older, but we’ve never specifically talked about how long it’s been going on. But he does say frequently that he will be in therapy for the rest of his life because he thinks of it as a place to just sort of come and think through life issues, but just sort of day to day issues as well. So, in his mind, he’s in it for the long haul.

Carla, who discussed two cases, reported that she discussed the length of therapy with Sylvia, but not with Barbara:

In the beginning with Barbara, we didn’t specifically discuss the length of therapy...but she had indicated ‘like look, I’ve been in therapy almost my whole life, I haven’t been in therapy for a while, but my life is falling apart, I know I need a lot of help...’ She kind of came in saying like ‘this is going to take a while, this is going to be hard, like, we have a lot to work with here.’ And so we kind of just assumed that it would go on, but never said like ‘okay, let’s meet for 6 months and see how it is,’ we kind of just left it at knowing that it would be a while. And then with Sylvia, I did ask her from the beginning, you know, ‘how long do you expect to meet’ and she said a year. And then a year came and passed, and she said, ‘well I guess I want to continue until I move away from here,’ knowing that when she finished the job she’s currently in, she was going to be moving.

Stephanie did not recall discussing the length of therapy with the client. She noted in the interview, however, that she remembers being somewhat aware of the possibility that the case could become long-term:

...she had a history of being in therapy, she tended to do better in therapy, so there was some indication this could be a long-term case, but at the same time, I feel like you never really know. I mean so much, I think, is dependent on the relationship and I think after some initial treatment plan or some one hour intake, you can't really know whether you have this powerful connection with her and whether it's going to last a long time...I think also I was a relatively beginning therapist at that point, so I feel like my knowledge and understanding of what could be a long-term case and what might not be was very different then than what it might be right now.

In only one of five cases was treatment length discussed directly with the client. Carla and Sylvia's discussion of treatment length took place early in the therapy in the context of treatment planning, where the therapist actively involved the client in the process by clarifying the client's treatment request and expectations.

In the other cases, discussion of treatment length took place at various points in the therapy, but in an indirect manner. Therapists were not directly questioned regarding the reasons treatment length was not explicitly discussed. Moreover, none of the participants was able to definitively recall how they were thinking about the length of therapy initially without being influenced by the evolution and status of the case at the time of the interview. There appeared, however, to be an assumption of long-term therapy underlying treatment planning that was true for all and, in all cases, this assumption was based on the complexity of the client's presenting problem.

The reasons for addressing treatment length indirectly, as was done in four of the cases presented, are unclear. It may have been discussed with regard to treatment planning or process, or it may have been in the context of reflection at the time of



termination. The question of the influence of an explicit discussion of treatment length and expectations on the course and length of these therapies is an important one; however, the present data do not inform its answer. The rationale of arguments both for and against such discussions is compelling, but mostly theoretical, so a more systematic inquiry is warranted. This issue will be revisited at a later point.

#### Therapists' understanding of the reasons these cases are long-term

Linda reported that Kimberly was initially assigned to her because it was expected to be a “difficult” case and she had some clinical experience. She added that what was considered “difficult” about Kimberly’s case was the likelihood that there would be “quite a bit of affect.” When asked broadly why she thought the case had been as long-term as it had, she stated, not surprisingly, that there were “a lot of reasons for that.” She continued,

...The way I conceptualized this case when I first picked it up, and this has been a work in progress, in terms of understanding this person...When I picked up this person, the therapy just prior to me working with her had centered around the diagnosis of PTSD, that this person had PTSD, and that originated I believe in [a therapy prior to the client’s treatment at the PSC]. And so when I picked her up, she had worked with the therapist prior to me and the work centered around trauma and even doing some memory work of the trauma, and certainly the diagnosis, and I was really struck by how much she identified herself with this diagnosis and I felt that we really had to work on separating her from the diagnosis, because the diagnosis of PTSD and seeing herself as dysfunctional was really getting in the way of functioning, sort of continuing on with life and progressing as an adult and I think those issues were complicated by the fact that she really had a lot to do developmentally to really feel like she was really moving into adulthood and taking on responsibility for her own life and I think she really resisted it and so there were a number of really complex factors that I felt were coming together. She really was stuck in not functioning...she wasn’t functioning in her life, and it seemed really complex and I know, I didn’t know it was likely to this long, but I felt ‘we’ve got a lot of work ahead of us to help her to understand herself in another way besides dysfunctional,’ as she would put it, [a] broken person, who was forever, you know, almost ruined by some of the events that had happened to her...a traumatic relationship, really...



Linda noted that she had initially thought the therapy could move more quickly, but that her initial, somewhat “aggressive” approach had “backfired” and ruptured the alliance, resulting in the worsening of Kimberly’s symptoms, which she understood as the client’s reaction to a coping strategy being withdrawn prematurely. She spoke about her perception that Kimberly was “not coming from her own center at all and had to develop that,” as well as a sense of “agency and [ability] to cope and deal and function.” When asked whether she believed the absence of that centeredness and sense of agency to be enduring characteristics, Linda stated that she believed it to be a result of earlier experiences in the client’s life as well as her family’s manner of coping.

Regarding Steven, who has been in therapy at the PSC for 10 years, Janet began by saying:

...the biggest reason that it was long-term was because [a close family member] told him that he needs to be in therapy for the rest of his life...So it began that way, but now I think he owns his therapy much more than he did in the past...But outside of that, I think now it’s long-term because he has some pretty pervasive discontent with his life and has a hard time initiating changes and so he takes sort of baby steps...in addition to the fact that a lot of his problems seem to stem from [interpersonal relationships], and obviously [those are] ongoing.

The fact that Steven is slow to implement changes, particularly in the context of interpersonal relationships, implies that it would take him a long time to make significant changes, which might indicate the need for longer term therapy.

Carla reported that, when Barbara called the PSC, she identified several problems, including a history of substance abuse, sexual and emotional abuse, trauma, and an extensive treatment history spanning 20 years. Carla indicated that she believed this complex problem presentation to be the reason that Barbara has remained in therapy for such a long time.

Carla also cited her belief that a psychiatric consultation was warranted, given the client's clinical presentation, as a suggestion of the complexity and pervasiveness of the presenting issues and therefore as further indication that Barbara would need longer term services. Carla's response to what kind of medication she thought Barbara might have benefited from further speaks to her understanding of the client's problems as pervasive and complex:

Well, I think she could benefit from some kind of meds for whatever it was, because she just talked about so many things that, like major depression, so, but ADHD was an issue because she was unable to hold a job down at that point and was also trying to take classes...and could not ever finish her assignments..., but also because she was interpersonally challenged, particularly in the work area, which is why she couldn't hold a job.

Carla believed that one of the reasons Sylvia's case was long term was the nature of her treatment request:

...one of her issues was wondering if she was at risk for developing mental illness like [a family member] had and she was at like this prime age where, if you're going to develop schizophrenia, you're most likely going to have a break in this age bracket. She was like dead center on the age bracket. And so she was requesting therapy as a way to monitor her mental health, so it's not like you do that in 12 sessions.

Perhaps the most manifest reason for the long-term nature of this case is the client's own notions of therapy: "She considers herself a lifetime therapy candidate, I guess...She kind of says, 'I'm going to be in therapy my whole life; that's just the way it is.'"

Stephanie believed one of the reasons Lydia was in long-term therapy was the fact that she had a number of long-standing problems, including a history of childhood sexual abuse, an eating disorder and difficulties in relationships with men.

With a lot of these things, it wasn't like she had a phobia; she didn't have sort of a concrete problem, she wasn't socially phobic, she didn't need to confront someone about some issue, it wasn't like she had...She had a lot of really dynamic or long-standing issues, real negative relationships with men; her father

left her when she was young and wasn't really in the picture. A lot of these things just seemed like issues that you deal with in long-term therapy, you know, they're not easily resolved in a few sessions.

When asked to describe in a nutshell why she thinks this case is long-term, Stephanie replied: "You know, it's really simple, but this person has a lot of trauma in her life and having a support system always in place that really carries her through transitions has been really helpful for her in the past, so I think that is really key..." She further expressed that she believed the history of trauma to be crucial, "...because a lot of people, you know, we have things that come up in our lives and we need to deal with them and we have certain relationship issues or dynamics and we're in therapy for a year, maybe even two years, but trauma takes a lot longer to deal with and you're always dealing with it to a certain extent."

The dominant theme that emerged regarding therapists' understanding of reasons why these cases are long-term is that of problem complexity. Linda, Janet and Carla explicitly used the words "complex" and "pervasive" to describe the problem presentation of the clients they discussed. Their descriptions of presenting problems as complex included characteristics such as difficulty with regard to affect, the client's view of herself as dysfunctional, trauma, multifaceted presenting concerns as opposed to a specific problem and the need for medication. The enduring nature of problems, another component of Beutler and Clarkin's (1990) definition of problem complexity, was addressed by Stephanie when she described Lydia's problems, including a history of sexual abuse, eating disorder and difficulties in relationships with men, as "long-standing." She underscored trauma as the most salient of these problems, asserting that

trauma takes a long time to work through and that survivors of trauma are "...always dealing with it to a certain extent."

Only one therapist, Janet, mentioned the influence of "external" factors on the length of therapy, citing the example of Steven's family member's insistence that he be in long-term therapy. This is an explicit and specific reason for why this therapy may have lasted as long as it has; however, it is the factor upon which Janet placed the least emphasis in her discussion of the case. She emphasized personality and situational characteristics, such as pervasive discontent and slowness to change as well as unfulfilling interpersonal relationships that continue to generate problems that must be addressed in therapy. It may be argued that the external requirement of remaining in therapy itself is less relevant than personality characteristics of the client that allow it such influence. More directly, perhaps the relationship between Steven's low self-esteem and pervasive discontent with his life, and such an external "requirement" is bidirectional in that it undermines his own sense of agency, leading to self-doubt and therefore continued dependence on the advice and opinions of significant others. It should be noted that the therapist might be one of the individuals to whom Steven turns for guidance and support which may, in turn, perpetuate an already problematic tendency towards dependence, a dilemma that has often been cited as evidence against long-term therapy (Budman & Gurman, 1988).

#### Relation of therapists' decisions regarding length of treatment to clients' treatment requests and notions of therapy

Clients' initial treatment requests were crudely assessed by examining their answers on questions on the Personal History Questionnaire (PHQ), a form requesting family and other background information that all clients are asked to complete at intake.



The two questions that are most relevant here are (1) About when do you expect this therapy to end; and (2) Do you expect to use therapy again in the future after this therapy is finished? If so, how?

Kimberly indicated that she expected this therapy to last two years. She did not indicate whether she expected to use therapy again in the future. Her request for long-term therapy is consistent with Linda's understanding of the reasons why this case was long-term and her conceptualization of Kimberly's difficulties as enduring and pervasive. Linda's recommendation of insight-oriented psychotherapy to explore experiences in Kimberly's past that contributed to her current difficulties is consistent with the client's request for treatment to address "anxiety due to a past abusive relationship."

Steven indicated that he expected this therapy to be "ongoing." While this treatment request is consistent with Janet's understanding of why this case is long-term, in terms of his pervasive discontent with his life, it may be contrasted with her goal for this therapy (discussed below), which was for him to become independent and terminate therapy as quickly as possible.

Sylvia indicated "Don't know" for when she expected this therapy to end; however, she indicated that she did expect to use therapy again in the future: "Yes, I always want to have an outlet that is independent of my social circle." This is consistent with Carla's understanding of why this case was long term, specifically in terms of how the client used therapy. Barbara left both questions blank.

While Lydia did not indicate when she expected the therapy to end, she indicated that she did expect to use therapy in the future: "Yes, I'll probably be in therapy for years." The close relation of this statement to Stephanie's understanding of the reasons



this case was long-term is evident in her statement regarding the client's trauma history and the need for her to have a "support system always in place that really carries her through transitions."

How therapists in training conceptualize long-term therapy: how long is long-term?

When asked how she conceptualized long-term therapy, Linda initially responded by saying that it was a difficult question to answer and that she didn't have an idea in her mind of what she would classify as long-term. She added that she thought it might be easier to define short-term, which would affect long-term, so if short term is a couple of months, long-term would be a year or more.

Janet's initial response was that she didn't really know what she thought about it and that she was still trying to figure it out. She noted that she had had all of her clients for close to a year at the time and that that seemed like a long time, "...but I guess in my head, when I think of the term long-term psychotherapy, in my mind that suggests more than a couple of years. But it still seems to me like a year feels like a long time. Like I would have hoped that they would've gotten what they needed and be gone by now, you know?"

Carla commented that it was a difficult question and that it was a difficult concept to define, because she did not think of it in terms of being bounded by a certain time period:

I feel like long-term therapy, I guess in comparison to short-term, is more open-ended and undefined in terms of the time period, so for example, short-term therapy, in my opinion, that's therapy where you set a limit. You say that like in 12 sessions we're going to establish and work towards these specific goals, whereas with long-term therapy it's just like you don't have that limit and you just work towards whatever goals you establish in the beginning, knowing that they can be revised over time or that new ones might come up and it's just more

flexible therapy, but that long-term therapy for some people is several years and for other people it's 8 months...

Stephanie stated that she thought it seemed subjective and, although she was sure there must be a textbook answer somewhere, she did not know what it was. After a moment's consideration, she said that she thought long-term therapy would be a year or more; however, when I mentioned defining it in terms of number of sessions, for example 52, she disagreed, saying that she would define long-term as 35 or 40 sessions or more. She added that this was influenced by the fact that she had seen clients for only 40 sessions, although not necessarily on a weekly basis, and therefore considered them long-term as well.

Two of four participants defined long-term therapy as one year or more and one defined it as longer than two years, all of which are consistent with the literature (Crits-Christoph and Barber, 2000). Carla stated that she did not think of long-term therapy as bounded by a certain time period, but rather made the distinction between open-ended and time-limited therapy, equating open-ended with long-term and time-limited with short-term. Furthermore, she asserted that what she might consider long-term varies between individuals, with 8 months being long-term for one and several years being long-term for another. Carla's point of view again raises the issue of distinguishing between time-limited and time-unlimited, or open-ended, therapy and raises the question of whether it might be more useful to approach the topic within that framework than that of short-term and long-term therapy. This question will be addressed at a later point.

#### Therapist views regarding the goals and success (or failure) of psychotherapy

For Linda, the goals of psychotherapy are individualized and largely driven by the client and, specifically, the presenting problem:

I guess I could say that when somebody comes into therapy with a presenting problem, or an issue that brings them in, that that begins to guide treatment and the goals. And then from that evolves [sic] other goals that maybe were not the presenting problem. And you know, it's salient today because in the termination session with this client, we returned to the initial problem she identified in the treatment - those three problem areas that we have - and she also reflected on how those were not the only problems, by any means, you know, so I think that's where the treatment starts. The goals come out of the presenting problem, but then from there, other goals develop, so that you can't really see all the goals at the outset.

She added that, although at times she thought that she had the goals in mind for clients she was working with, she had to remind herself that those might not have been the clients' goals and that the direction she had in mind for the therapy might not have been the direction it was moving in at all.

Regarding success of therapy, Linda expressed the following:

...one thing that I've really come to identify as success in therapy is if I have worked with a client and they feel connected to me and we've developed a strong alliance, but when it comes time to part ways, if the client feels that they're connected and they're going to miss me, but they don't need me, I feel that that's a tremendous success. That I've managed to walk that line, really been with the client and I've helped the client, and I've been connected to the client, but I haven't given them a sense that without me they can't take the work with them that we've done and have it, have an internal sense of the progress that they've made on their own. That I think is a tremendous success and I've been aware of that lately because like this client we're talking about, you know, she pretty much said, you know, I'm going to miss you, but I'm going to be okay, I'm going to be just fine, more or less, so you know that's a success. And certainly if the person feels that they've addressed things that brought them into therapy and that they feel a sense of resolution or more stability of progress in areas that they identified. That would be another way of having success.

Linda defined failure of therapy in terms of the client making progress on one hand and the development of the therapeutic relationship on the other. She acknowledged that it might take a long time to see progress in a client who has severe pathology, but maintained that, if treatment is not facilitating progress over a long period of time, "...that would be a failure and it should be considered whether the client should

go to another therapist or another treatment setting or address a different area.” Linda also identified failure as the therapy never “get[ting] off the ground...because the alliance never formed or something impeded the actual therapy from going.”

Janet broadly defined the goal of psychotherapy as change. She also spoke specifically about the way she thought about the goals of therapy for Steven:

It’s my goal, by the time I leave here, to have sort of weaned him down to maybe one session every two weeks or one session every three weeks. I don’t know if that’s realistic or something that he will ever agree to, but I think he could do that, if he’s able to continue to make some substantial changes. And by substantial changes, my goal and his goal is sort of to learn to become as independent as possible and learn to make his own decisions without having to check it out with other people and feel like he likes himself and he’s good enough as he is.

The goal of independence is manifold in that it refers most obviously to his life and relationships outside of therapy, but may also refer to his relationship with therapy and his therapist. When asked whether her conceptualization of the goals of therapy with Steven differed from the way she conceptualized the goals of therapy in general, she said that she did not necessarily think so, but that she had, to some degree, “molded” herself into a different way of thinking in her work with him. She indicated that she understood this in terms of the fact that she entered her work with him as the third or fourth transfer therapist over a period of almost 10 years and, by virtue of being a relatively beginning therapist, had merged into a legacy of approaches to understanding and treating Steven that did not necessarily match her own.

Consistent with her view of the goals of psychotherapy, Janet defined the success of therapy as making substantial changes in identified problem areas. She acknowledged that Steven had gained some insight into himself and his problems over the course of 10 years in therapy, but expressed frustration at his failure to make substantial changes and



to move in the direction he wanted to move in. She speculated that this was due, in part, to some of the approaches used by previous therapists that appeared not to work for him. She added, however, that he was not unhappy with therapy:

He is very content with therapy...He would be content for me to come in and sit there while he talks for 50 minutes straight. I wouldn't have to say a word. So it's not like he's unhappy with it, but I think in some ways, I almost feel like it's done a disservice to him. He shouldn't have had to have been here for 10 years and been stagnant the whole way.

Janet admitted that she did not believe Steven's therapy to have been helpful at the point of transfer from the previous therapist based on the fact that he was still presenting with many of the same issues he had in the beginning; however, she reiterated that he had gained insight into his motivations and added that she believed his previous therapists to have been helpful in that regard.

Carla stated that she believed the goals of psychotherapy to be "individualized to the person in psychotherapy." Although she began by saying that she thought it would be difficult for her to think of what the common goals for everyone would be, she did name a few goals that might be considered "general" or common:

I guess the goals are to define why the person's in therapy, and then establish some reasonable goals within your time, within your framework, how much time you have to work with that person, and figure out whose goals those are...and then seeing how far you can get with respect to achieving those goals...So that's one broad common factor in terms of psychotherapy with everyone – just making sure what you're doing is clear between the therapist and the client and seeing how well you can meet those goals. But there's [sic] all these other things that I consider important, like establishing the therapeutic relationship and continuously monitoring that over time...I'd consider that an ongoing goal.

With regard to the goal of "figure[ing] out whose goals those are," Carla admitted that she has difficulty determining whether she is working towards the client's goals or



her own goals and finding a balance between which is more important in a particular situation.

Carla defined success as the client finding the therapy helpful, as well as meeting any of the goals that were set. She also identified trainees' learning experiences working with clients in psychotherapy as a component of success: "...I just realized, as a beginning clinician, you kind of have to see almost everything you do with a client as successful because you just have to figure out from your experience what you gain from it as a trainee." While Carla viewed success in terms of both the therapist and client, she emphasized the client's perspective:

...I think when you weight it, ultimately everything from the client's perspective is more important...again, I'm thinking of [Sylvia] because I'm constantly wondering if we're doing anything, like does it help for her to come in and talk to me week after week, but she's obviously finding it helpful in some way...any person who comes back month after month after month must be getting something out of the work and, as long as she's finding it successful, it must be and that's more important than whether or not I really find it successful for her. What's helpful is if I find I'm learning anything from it.

According to Stephanie, the goals of psychotherapy are to "...[help] [the client] to gain some degree of insight, and through that, some degree of relief through understanding of their problem and how they work and feel some sense of control or agency over that process – that things aren't sort of just happening randomly, but actually, we're compelled to act in certain ways because of our early experiences and our relationships and things about us...I think the goal of therapy is to help this person to do the work that maybe the therapist is doing initially, the probing and the prompting and the asking questions. Ultimately, the goal is for the person to be able to do that work themselves, as the therapist...You do get skills from being in therapy, you learn ways of

asking questions and of thinking about your life and trying to understand why we do things that we do.”

When I asked Stephanie how she thinks about the success or failure of therapy, she hesitated at first, commenting that “it’s so black and white;” however, she continued, defining successful therapy as “...some sort of agreement by both the therapist and the client that things are better, that the client’s feeling better, that both people feel like there’s some positive change. Pretty simple. And then I guess failure would be no change or worsening as a result of the therapy...”

Although questions regarding the goals and success or failure of psychotherapy were posed independently, in all cases the distinction appeared unnecessary; that is, success and failure were, not surprisingly, conceptualized by all participants in terms of the goals. For this reason, therapists’ understanding of the goals and success or failure of therapy will be integrated in this discussion. All participants indicated that the goals of psychotherapy should be tailored to the individual needs of each client at a given time in the treatment; however, each also noted one or more overarching goals of psychotherapy that provide the framework for the development and accomplishment of specific goals. Both Linda and Carla emphasized the therapeutic relationship as a goal of psychotherapy. Linda spoke of a strong alliance as the context within which clients can develop an internal sense of progress and agency, whereas Carla identified the establishment and maintenance of the alliance over time as primary and ongoing goals.

Carla added another dimension by defining success of therapy in terms of the subjective experiences of both the client and the therapist. Specifically, she asserted that a therapy could be considered successful if the client found it helpful; furthermore, she

suggested that beginning clinicians should view all work with clients as successful in that there is always something to be gained as a trainee. This point of view is refreshingly honest and serves as a reminder of the value of trainees' unique positions and perspectives in understanding psychotherapy process; however, client and therapist views regarding therapy outcome often differ (Todd, Deane & Bragdon, 2003).

Both Janet and Linda included the notions of change and progress in their conceptualization of the goals and success of therapy. Linda presented it as one facet of understanding of the success of therapy, whereas Janet presented it as the single most important determinant of the success of a therapy. Janet's perspective differs not only from Linda's, but from Carla and Stephanie's as well. One way of understanding this is in terms of the way theoretical orientation might influence views of the goals and success of therapy.

Linda described her current theoretical orientation as integrative and added that she conceptualizes cases within a psychodynamic framework. Carla described herself as integrative in her approach to treatment. When asked whether she tends more towards one theoretical orientation in her conceptualization of cases, she hesitated to specify any particular approach at this point in her training; however, she expressly stated that she leans away from a cognitive-behavioral orientation. Janet described her theoretical orientation as cognitive-behavioral. Stephanie firmly stated that her theoretical orientation is psychodynamic; however, she added that she employs an integrative approach to treatment. Janet's approach to the goals of psychotherapy is more concrete than are Linda, Carla and Stephanie's. This is consistent with a cognitive-behavioral approach to therapy, where concrete goals are established and approached within a

discrete time period that is determined at the onset of treatment. Linda, Carla and Stephanie all characterized their treatment orientation as integrative. An integrative approach implies more flexibility in that multiple approaches to treatment may be employed individually, or integrated, at different times during the course of treatment, in accordance with current goals.

#### Client problems and characteristics for which therapists would recommend long-term therapy

Linda stated unequivocally that she would recommend long-term psychotherapy for individuals with severe character pathology or personality disorder diagnoses; however she added that such a recommendation would be influenced by the goal of the therapy: “I could see that if somebody had a personality disorder, but was basically doing okay and wanted to come in because, I don’t know, they’re going through a difficult time and want couples therapy...If the person isn’t committed to making changes in other areas, then they could possibly benefit from short-term therapy for a specific problem area.”

Linda cited the GAF (Global Assessment of Functioning) scale as another consideration in her recommendation of long-term psychotherapy, asserting that an individual with a low GAF rating would need longer-term therapy to stabilize: “...somebody with a severe depression, with psychotic features or something, who has several problems that center around that major problem; maybe the person’s homeless, the person is totally isolated, has no supports.”

Finally, Linda noted that problem complexity might influence her recommendation of long-term treatment: “Complexity would also determine the need for



lengthier treatment if there's [sic] a lot of problems that center around the main problem area that need to be addressed for the person to stabilize."

Janet began by stating that she would recommend long-term therapy for pervasive mental illness, citing schizophrenia or bipolar disorder as examples: "...that's going to take a lot of work, because there are so many different facets that you're going to have to address and I think a weekly check-in for people dealing with things like that is probably sort of a necessary thing." She also noted that she thought longer-term therapy would be indicated for "people who have a pervasive distrust of either professionals or people in general," because "you're going to have to spend more time working on building a relationship before you can really do good work." Conversely, she stated that she did not think she would recommend long-term treatment for anxiety and depression, or life transition and relationship issues; however, she qualified this by adding that it would depend on how entrenched those issues were:

You know, somebody who's been in an abusive relationship for 10 years and they've been beaten weekly and they've got a couple of kids; yeah, there's probably going to need to be not only a lot of support and a lot of processing done, but also the logistics of finding a place to live, and I would think that that would consume a large part of the beginning of the therapy.

Carla unhesitatingly said that she would recommend long-term therapy if a client's clinical presentation was "very complex, and what I mean by that is, there's not a very straightforward, defined issue." She then gave an example of someone presenting with a specific phobia, that could conceivably be treated in 6 to 12 sessions and contrasted this with her client, Barbara, who presented with, among others, social anxiety, ADHD, borderline personality disorder, and inability to hold a job or maintain an intimate relationship. Carla elaborated on this example by saying that, if there were a



number of issues to be addressed in therapy, it would necessarily take longer.

Furthermore, Carla asserted that chronic, pervasive problems would necessitate longer term therapy: "...so, personality disordered individuals, I would recommend long-term therapy over someone who is suffering from a depressive episode, for example; which kind of goes with complexity, but more in terms of how pervasive the problem is." She said the following regarding the relationship between length of therapy and personality disorders or characterological problems:

I think characterological problems are known to be very difficult to do much with and, if you think about the beginning of any therapy being all about establishing some sense of rapport and relationship with the therapist, it seems as though, based on what I've learned and what I've read, and my own experiences, that establishing that relationship with someone who has characterological deficits is more difficult and therefore takes a bit longer of a time and you have ups and downs. So, I feel like it sets things back a little bit. Maybe that's a stereotype, but I definitely subscribe to it if it is, because I feel like those are the people who you end up spending more time with in therapy.

Stephanie stated that she thought the rationale for recommending long-term therapy was dependent on the client and whether their presenting problem was "something concrete or something more long-standing." After pausing for a few seconds, she commented on her tendency to equate long-term with insight-oriented therapy and to think of individuals with the capacity for insight as good candidates for long-term therapy. She then contrasted this with an example of chronically mentally ill clients, with limited insight, for whom long-term therapy would be indicated as a regular support for daily living. Stephanie reiterated her assertion that long-term therapy would be indicated for long-standing issues such as "relationship dynamics [and] trauma."

Stephanie specified that she would recommend long-term therapy in cases of trauma such as rape, abuse and incest, as well as for individuals with a "history of

destructive or maladaptive relationships that may or may not be related to certain personality structure and...I hate to use the word, but more borderline characteristics.”

In summary, there was a fair amount of agreement among the therapists interviewed regarding reasons for recommending long-term therapy, such as problem complexity, including chronicity and pervasiveness, character pathology and trauma. These themes will be revisited in detail in the next chapter.

## CHAPTER IV

### CONCLUSION

For the cases considered in the present study, length of treatment was not explicitly mentioned in the initial treatment plans, nor did therapists recall that it was discussed in supervision or with the clients in the early stages of treatment. Consequently, most of these cases took an "open-ended" and "implicit" approach to defining treatment length, presumably with the underlying rationale being that therapy should continue until the client, or ideally the client and therapist, decide that it is time to stop and that the goals of treatment have been achieved. This may be due, in part, to the nature of the PSC as a training clinic that operates on a sliding fee scale and rarely has a full caseload. The absence of external pressures such as waiting lists and insurance restrictions allows a flexibility that is rare in other treatment settings.

It should be noted that, since only a limited number of long-term cases were considered, it cannot be concluded that all therapists, supervisors and clients in the PSC adopt an open-ended approach to treatment planning. What the present data were able to provide, however, are detailed accounts of some of the ways that long-term cases may evolve within this specific kind of environment. Factors that may contribute to the maintenance of an open-ended, and in these cases long-term, model are the theoretical orientations of therapists and supervisors, therapists' individual and perhaps personal reasons for extending therapy, and clinically relevant factors such as client characteristics and problems.

In the present study, therapists' observations regarding why these cases were long-term are consistent with Beutler and Clarkin's model of Systematic Treatment Selection (1990). This is notable given that none of the participants reported being familiar with this model. Although none of the present findings significantly challenges Beutler and Clarkin's model, there are some subtle variations that will be discussed in further detail where appropriate.

### Rationale for Recommending Long-Term Therapy

The data from this study were consistent with Beutler and Clarkin's (1990) model in identifying problem complexity as a major reason for recommending long-term therapy. Participants explicitly distinguished between complex, multidimensional problems, and specific, focused problems. They described complex problems in terms of pervasiveness, chronicity, and the number of different issues a client presented with. Examples of specific problems were anxiety disorders, such as phobias, and life transitions. All participants agreed that they would not recommend long-term therapy for clients seeking help with specific, focused problems that are generally situation-specific and acute.

The present data yielded two themes regarding the relation of problem complexity to long-term therapy. Firstly, problem complexity can be understood in terms of complicated, multifaceted problems whose elements must be addressed individually, perhaps even sequentially. Secondly, there are cases where a substantial period of time is required to prepare the client to do the work of therapy, either in terms of stabilizing their symptoms or establishing the trust necessary for development and maintenance of the therapeutic alliance. The first case may be illustrated by the example of someone who is

working to improve her self-esteem, function more independently and negotiate intimate relationships more effectively in terms of her own needs. These issues may be addressed concurrently in therapy; however, that might be particularly challenging in a case such as this. If they were addressed sequentially, self-esteem might be the primary focus which, as it improved, might foster greater independence, and influence the way the individual negotiates interpersonal relationships; however, improving self-esteem might require insight into dynamic issues in an individual's family of origin, a process which will likely be lengthy. Insight may also promote growth and change, factors that influence interpersonal relationships enormously. As an individual begins to change, so too might the relationship, which may then become the next focus of therapy. Validation of the example above is beyond the scope of the present study; however, one or more in-depth case studies might illuminate some of the ways in which complex problems are addressed in long-term psychotherapy.

The amount of time necessary to prepare to do the work of therapy depends on a number of factors, a few of which are the client's motivation for change, psychological mindedness or familiarity with the therapy process, capacity for insight, level of functioning, personality characteristics, and psychiatric history or presenting problems (Beutler & Clarkin, 1990). Surprisingly, motivation and psychological mindedness were not raised in the interviews in relation to treatment duration; however, Beutler and Clarkin addressed both as key factors in treatment planning. The fact that a client pursues therapy may not necessarily imply that she is motivated. Individuals who present for therapy at the request of a family member or pursuant to a legal mandate are one example of clients who are less likely to be motivated; indeed, they are often actively



resistant and it will likely take a long time and a lot of work for them to trust the therapist enough to engage in the therapy process. This resistance is also related to Beutler and Clarkin's concept of interpersonal reactance, which they define as "an individual's likelihood of resisting threatened loss of interpersonal control."

Psychological mindedness has some relation to motivation in that individuals who are not psychologically minded are unlikely to be motivated to seek help through therapy; however, it may simply be that individuals who have never been in therapy, or who are not psychologically minded, might require a period of time to "learn" how to use the time productively. In this sense, psychological mindedness is related to insight and, while insight might not be necessary for behavioral change, it may be necessary for enduring change with regard to a number of factors that the data have suggested as indicators for long-term therapy, including character pathology and complex, pervasive, long-standing problems. Consequently, the time devoted to developing insight is crucial and therefore a sound rationale for long-term therapy. Insight is also related to problem complexity in that some have argued that the more complex the problem, the more the treatment objectives should be focused on the driving, underlying conflicts, and the longer the therapy will be (Beutler & Clarkin, 1990; Crits-Cristoph & Barber, 2000; Kopta, Howard, Lowry & Beutler, 1994).

Level of functioning was explicitly addressed by one therapist in the context of recommending long-term therapy. She asserted that the relevance of this factor is in the time needed to stabilize a client enough to where goals can be addressed. She emphasized this with an example of someone "with a severe depression, with psychotic features, who has several problems that center around the main problem; maybe the

person is homeless, totally isolated, has no supports.” This illustrates the relation between level of functioning and problem complexity and is consistent with past research that shows clinicians’ ratings of Global Assessment of Functioning (GAF) at intake to be predictive of recommendations for treatment length (McRae, 1998).

Personality disorders were identified by three of the four therapists as virtually intuitive reasons for recommending long-term therapy. The most salient rationale for recommending long-term therapy in the case of character pathology was the difficulty these individuals experience in interpersonal relationships, specifically, the absence of, or difficulty developing, trust. This may imply longer-term treatment given that the time necessary to develop a secure working alliance would be extended, thereby delaying the opportunity to work on core issues. Moreover, for these individuals, core issues are frequently multidimensional, pervasive and enduring, which again highlights the issue of problem complexity and, by implication, longer term treatment.

Trauma encompasses a number of the issues already addressed, most notably its influence on interpersonal relationships, and the pervasive and long-standing nature of the difficulties that result from it. Trauma history will likely delay the development of trust in the therapist, an essential element in the therapy process and one whose absence precludes progress. In the case of sexual abuse, the trauma itself is inextricably linked with interpersonal relationships, trust and intimacy. The necessity of long-term treatment in such a case appears intuitive; however, this intuition is grounded in a number of very real factors. One such factor is the development of trust in the therapist, which is likely to be a slow process given the violation of trust inherent in abuse. Another is the complexity of the treatment approach; specifically, the need for insight, working through

and, ideally, the provision of a corrective emotional experience, which is particularly dependent on the strength of the therapeutic alliance.

Another factor therapists consider in treatment planning is the identification of a focus to guide the treatment. Participants indicated that cases that have a clear, defined focus are unlikely to require long-term treatment; however, cases where a focus has not been identified are likely to be longer term. For example, an individual with a dual diagnosis of borderline personality disorder and a specific phobia might benefit from short term treatment if the treatment focus is the specific phobia; however, that same individual might need longer-term treatment to address functioning and communication in interpersonal relationships. This is related to clients' treatment requests in that clients in the PSC are asked to identify on the Personal History Questionnaire (PHQ) what problems they would like to focus on in therapy and when they expect therapy to end. Clients are also asked to indicate how long-standing they believe these difficulties to be. In this case, the rationale for long-term treatment is less clear-cut, given that although certain diagnoses, for example, panic disorder, may be long-standing, they can be treated in a relatively short period of time. Again, this depends on the goals or foci of the therapy. The symptoms of panic disorder may be treated successfully in brief treatment; however, if one of the client's identified goals is to gain insight into how and why she developed panic disorder, that is likely to be a longer process. Furthermore, there is some evidence that treatment of specific problems is less effective for clients with comorbid personality disorders (Sanderson, Beck, & McGinn, 1994; Diguier, Barber, & Luborsky, 1993). There is also some indication that the focus can, and frequently does, shift over the course of treatment. In a study of time-limited treatments, Hatcher, Huebner and

Zakin (1986) found that “the longer the time-limited therapy progressed, the more likely it was that the focus was revised between the time of the initial consultation and termination.”

### Relation of Long-Term Therapy to the Training Process

It is tempting to assume that a long-term, open-ended model such as that employed in the PSC would be unequivocally beneficial in terms of training. One assumption might be that longer equals better and that the quality of the work, and therefore what is learned about psychotherapy, improves as length of treatment increases. Furthermore, there is time to develop a quality working alliance without the pressure of it having to be developed quickly and without the risk of rupture by challenging the client’s defenses prematurely, that is, before the environment feels safe enough to do so. On the other hand, long-term cases may be frustrating for beginning therapists, perhaps in terms of slowness of change, or the practical issue of working with a range of clients, with a range of problems and levels of functioning, the opportunity to use different treatment approaches. The maximum individual caseload in the PSC is 3 clients at any given time, and if one or more of those continues over an extended period of time, the opportunity for contact with diverse clients is significantly compromised. Furthermore, one of the most relevant training issues currently is the importance of learning to work within a brief treatment model since that defines the majority of treatment settings in this country. Although many clinicians argue that long-term therapy is an important training experience that may provide a necessary foundation for doing short-term therapy (David Todd, personal communication, November 13, 2003), brief therapists argue that graduate training programs need to provide specific training in brief therapy in order to prepare



therapists to work effectively in the current health care environment (Levenson & Evans, 2000).

One of the participants in the present study noted that her thinking about long-term cases was less sophisticated at the time she began work with the client than at the time of the interview; specifically, she stated that she had less of an understanding of what kinds of cases may have become long-term or for what types of clients she may have recommended long-term therapy. This raises the issue of the role of the therapist's level of experience in treatment planning. Even if the need for long-term therapy was evident for a particular client, the structure of the clinical and academic curriculum results in an absence of relatively more experienced therapists who would remain in the PSC long enough to continue such long-term psychotherapy. This results in the need for inexperienced therapists to take on complex and "difficult" long-term cases, either as first therapists or as transfer therapists in cases that have been transferred once or multiple times. As one therapist noted, this results in beginning therapists merging into a legacy of treatment that may or may not be consistent with their own personality, theoretical orientation or style of intervention. While therapists may still learn from this by being exposed to new ways of conceptualizing cases and working with clients, it may also undermine their development as clinicians.

#### Relation of Long-Term Therapy to Managed Care

The most effective distribution of limited resources necessitates the identification of client problems or characteristics for which long-term therapy may be indicated. According to the existing literature, patient characteristics that tend to lengthen treatment are poor motivation, problem severity and complexity, and lack of social and family



support (Beutler & Clarkin, 1990). The data in the present study lent further support to problem severity and complexity as indicators for long-term treatment; these dimensions were represented by complex, pervasive, long-standing problems and personality disorders. Other factors that emerged as support for the recommendation of long-term therapy are the importance of insight in the therapy process, the lack of a defined focus, and clients' views of therapy as a way of life. All of the aforementioned factors provide a sound theoretical and, in some cases, empirical rationale for long-term treatment; the greater question is the likelihood of the endorsement of one or more of them for managed care. Indeed, this harks back to the widely held view in the brief therapy literature that long-term treatment should only be considered if brief therapy has been unsuccessful (Wolberg, 1965; Budman & Gurman, 1983). As Beutler and Clarkin (1990) argue, however, there are many situations in which time-limited treatment would be inappropriate even as a first trial. Character pathology may be one such instance, in that individuals who have difficulty connecting interpersonally may waste valuable time and resources in a series of short-term therapies in which they are unable to establish a working alliance with the therapist, and therefore unable to address core issues before moving on to the next short-term therapy. The same is true for clients with complex problems, who may only be able to address aspects of those problems in any one time-limited therapy. This raises the question of the effectiveness, both in terms of cost and benefit to the client, of one long-term therapy versus multiple intermittent brief therapies. It is likely that the answer will be different for different individuals; however, in the case of complex, severe, undefined and long-standing problems, it can be argued that clients would benefit most from one long-term intervention so that they have the opportunity to

develop an alliance with the therapist that constitutes a safe environment, and so that the therapy process can continue uninterrupted as long as is necessary. The answer seems less clear-cut for individuals whose motivation for therapy and change is low, and problem severity may be relevant in this case. Specifically, if clients with specific, unidimensional problems demonstrate low motivation for change, delaying treatment is a valid option; however, individuals with severe and complex problems that greatly compromise their functioning, and who are not motivated to change, present a challenge. Since these individuals are likely to be particularly difficult to engage in the therapy process, long-term therapy presents a more efficient treatment option in that it provides the opportunity for a cumulative effect of the work of therapy; that is, it may take these clients longer to engage, but once engaged, they have a sturdy working alliance on which to build and within which to address difficulties. If the same clients are subjected to multiple intermittent brief therapies, the process of developing trust, building motivation and engaging with the therapist must be repeated, thus inefficiently utilizing valuable time and resources.

#### Limitations, Implications and Suggestions for Future Research

The present data represent a small number of long-term cases and conclusions about other long-term cases in this training clinic and, long-term cases in general, must therefore be drawn cautiously. Furthermore, since short-term cases were not considered in the present study, there was no explicit basis for concluding that the short-term cases in this clinic differ from long-term cases other than in length. The perspective of interest was specifically that of therapists-in-training; however, that in itself limits the findings in that the participants, and other clinicians in this setting, have relatively limited theoretical

and clinical experience. Given that therapists in this training clinic carry a maximum caseload of three clients, one or more long-term cases might constitute a large part of their clinical work, in terms of time spent in session, in supervision, and in treatment planning (cf. “clinicians’ illusion,” Cohen & Cohen, 1984). It is therefore possible that these long-term cases seem representative of long-term cases in general, which may be a function both of the “clinicians’ illusion” and their level of experience. Moreover, since the cases included in this study were all long-term, it is possible that some or all of the therapists interviewed held a bias towards long-term therapy. The influence of theoretical orientation in this regard is unclear because therapists were not selected based on theoretical orientation and neither the sample size, nor the distribution of theoretical orientation among participants, allowed for a systematic comparison of views regarding long-term therapy based on theoretical orientation.

The results of the present study suggest that, in this training clinic, long-term therapy is rarely stipulated in the treatment plan and, when it is, it is seldom accompanied by an explicit rationale. Therefore, in the cases reviewed here, decisions regarding length of treatment were made “passively,” rather than “actively” as an overt component of treatment planning. Furthermore, the data indicate that client problems or characteristics for which long-term psychotherapy may be indicated can be identified, and are consistent with Beutler and Clarkin’s (1990) model of Systematic Treatment Selection as it applies to duration of psychotherapy. Future research looking at both long-term and short-term cases might illuminate whether, and how, the present data are specific to long-term psychotherapy cases and how the process of treatment planning in this training clinic in general relates to Beutler and Clarkin’s (1990) model.

For the cases considered here, therapists' recommendations and decisions regarding length of treatment seemed to be generally consistent with clients' requests; however, clients' treatment requests were assessed only by their answers to questions on the Personal History Questionnaire (PHQ). Further research looking in-depth at clients' treatment requests is necessary to enhance our understanding of the relation between therapists' and clients' notions of the goals of therapy, the effectiveness of therapy and the therapy process as they relate to treatment duration.

Table 1

## Comparative Value Ideals of the Long-Term and the Short-Term Therapist

Long-Term Therapist	Short-Term Therapist
1. Seeks change in basic character.	Prefers pragmatism, parsimony and least radical intervention, and does not believe in notion of "cure."
2. Believes that significant psychological change is unlikely in everyday life	Maintains an adult developmental perspective from which significant psychological change is viewed as inevitable.
3. Sees presenting problems as reflecting more basic psychopathology.	Emphasizes patient's strengths and resources; presenting problems are taken seriously.
4. Wants to "be there" as patient makes significant changes.	Accepts that many changes will occur "after therapy" and will not be observable to the therapist.
5. Sees therapy as having a "timeless" quality and is patient and willing to wait for change.	Does not accept the timelessness of some models of therapy.
6. Unconsciously recognizes the fiscal convenience of maintaining long-term patients.	Fiscal issues often muted, either by the nature of the therapist's practice or by the organizational structure for reimbursement.
7. Views psychotherapy as almost always benign and useful.	Views psychotherapy as being sometimes useful and sometimes harmful.
8. Sees patient's being in therapy as the most important part of patient's life.	Sees being in the world as more important than being in therapy.

*Note:* From *The Theory and Practice of Brief Therapy* (p. 11), by S.H. Budman & A.S. Gurman, 1988, New York, NY: Guilford.



Table 2

## Data from Pilot Interview

	Client 1	Client 2	Client 3
Reason for therapy	Believes everyone should be in therapy; personal growth	In long-term therapy per spouse's request (ultimatum)	Specific current issue
Personality Factors	Dependent		
Trauma/Abuse History	Childhood emotional abuse; still true for some interactions with parents		
Psychopathology	Substance abuse; past suicide attempt		
Usefulness of Therapy	Utilizes therapy effectively; continues to "do the work"	No longer actively working in therapy; possibly dependent on therapy	Works actively in therapy

Table 3

## Descriptive Case Information for "Open Pool"

	Age	Appointments	Sessions	Therapists
Minimum	18.00	1.00	1.00	1.00
Maximum	53.00	374.0	343.00	6.00
Median	26.00	17.00	15.00	2.00
Mean	29.09	55.09	47.19	1.87
Standard Deviation	8.90	82.16	73.65	1.18

Note. N = 31 (8 men, 8 women). "Age" represents the age on 10/25/02. "Therapists" represents the total number of therapists involved on this case

Table 4

Descriptive Case Information for “Closed Pool”

	Age	Appointments	Sessions	Therapists
Minimum	18.00	1.00	0.00	1.00
Maximum	61.00	304.00	227.00	7.00
Median	22.00	20.00	15.00	1.00
Mean	26.22	41.37	34.45	1.42
Standard Deviation	9.26	55.10	46.52	.86

Note. N = 137 (48 men, 89 women). “Age” represents the age at termination. “Therapists” represents the total number of therapists involved on this case.

Table 5

## Descriptive Case Information for "Interview Pool"

	Age	Appointments	Sessions	Therapists
Open Pool				
Minimum	18	59	49	1
Maximum	39	374	49	6
Mean	26.67	131	77	2.57
Median	30	17	15	2
Closed Pool				
Minimum	19	70	68	1
Maximum	51	304	207	7
Mean	28.80	151	122	3
Median	32	20	15	2

Note. N = 12 (7 open, 5 closed). "Age" represents the age on 10/25/02 for open cases or at termination for closed cases. "Therapists" represents the total number of therapists involved on this case.

Table 6

Descriptive Case Information for Interview Sample

	Age	Appointments	Sessions	Therapists
Minimum	18	59	49	1
Maximum	32	374	343	6
Mean	25	150	133	2.6
Median	29.5	102	83	2

Note. N = 5. “Age” represents the age on 10/25/02. “Therapists” represents the total number of therapists involved on this case.



## APPENDIX A

### INFORMED CONSENT FORM

This project will explore clinical trainees' values regarding treatment length and the process of long-term psychotherapy.

My participation in this study will consist of 1) taking part in a ninety minute interview; 2) reviewing a summary of my responses prepared by Jennifer Davidtz, the principal investigator; and, 3) if needed, taking part in a second interview to clarify the researcher's understanding of my responses. I understand that I will be asked to describe aspects of my clients, the therapeutic relationship and possibly my supervisory relationship. I understand that such description may include information regarding my theoretical orientation, my values regarding the goals of psychotherapy and treatment planning, and detailed description of the process by which a particular case or cases became long-term.

I understand that I may ask questions of the investigator at any point during the interview and that I may refuse to answer any question asked of me. I understand that I may withdraw from the study at any time. I also understand that I will not be penalized in any way should I exercise those choices.

I understand that all interviews will be audiotaped and that verbatim transcripts will be made from the tapes. All of the information I provide in this study concerning my clients, my supervisor and myself will be kept completely confidential. If information I provide is used for publication, my name and all other identifying information will be altered.

I have read and understand the nature of this project and what is required of me. I am willing to participate as a subject in this research study.

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Signature

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Date

## APPENDIX B

### INTERVIEW GUIDE

#### Therapist Values and Point of View

1. How do you conceptualize long-term therapy, specifically, how long is long-term?
2. What do you consider to be the goals of psychotherapy?
3. How do you conceptualize success or failure of therapy?
4. What are the reasons, if any, that you would recommend long-term therapy?
5. Are there any specific problems or personality characteristics that might lead you to specifically recommend long-term therapy?
6. How would you characterize your theoretical orientation at this point? *(To what extent do you vary (believe in varying) treatment techniques according to specific client needs versus approaching all cases from the perspective of your particular theoretical framework?)*

#### Therapy Process

7. Did you recommend long-term therapy in the initial treatment plan?
8. If long-term was recommended at the outset, what was the rationale for this recommendation?
9. If long-term therapy was not recommended initially,
  - a) Was it discussed and decided upon with the client at any point?
  - b) Did you specifically discuss the length of treatment in supervision?
  - c) Did the case develop into long-term as a slow process over time?
10. If the case developed into long-term over time, what are the reasons?
11. What was the process by which this happened? Was termination discussed at any point along the way?
12. Were there any instances where it made sense to terminate (e.g. end of school year), but you did not? If so, why not?

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